

# THE OBSERVATION STATUS PROBLEM

IMPACT AND RECOMMENDATIONS FOR CHANGE

Society of Hospital Medicine  
Public Policy Committee  
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Observation is an outpatient designation originally intended to give providers time to make a decision as to whether a patient needs to be admitted as an inpatient or discharged back to the community. This decision should ideally be based on the patient's condition and the provider's clinical judgment about the best course of action for the patient's care.

However, the intricacies of observation policy have created a situation where observation care is now commonly being delivered on hospital wards, indistinguishable from inpatient care. The frequency and duration of observation status has also grown significantly in recent years, well beyond its original intent. This is important because observation is not covered by Medicare Part A hospital insurance, and patients under observation are ineligible for skilled nursing facility (SNF) coverage at discharge, which may leave them vulnerable to additional complications.

As a result, observation status is the subject of increasingly intense scrutiny by both providers and patients. A recent rule change governing the application of observation status — Medicare's two-midnight rule — has galvanized the medical community and upended established systems.

Hospitalists are central players in the inpatient admission decision, often serving as the admitting physician. The Society of Hospital Medicine (SHM) surveyed its membership to garner their experiences with, and perspectives on, observation status and the two-midnight rule.

### **Hospitalists Reported Significant Concerns With Observation Status Generally and the Recent Changes Resulting from the Two-Midnight Rule, Including:**

- Lack of knowledge and confidence in implementing the two-midnight rule
- Disruptions to hospitalist and hospital workflow
- Decrease in the ability of hospitalists to make independent clinical decisions
- Negative impacts on patients, including access to SNF coverage and highly variable financial liabilities
- Damage to the physician-patient relationship

## Perspectives on Improving Observation Status Policy Informed the Development of the Following Recommendations:

### *Short-Term Improvements*

- Educate providers to raise proficiency and confidence in applying observation status rules.
- Educate patients on the intent and purpose of observation status as well as the impact of observation status financially and for coverage determinations.
- Change SNF care coverage rules to ensure patients are able to access the care they need as ordered by their hospitalists. At a minimum, count time under observation status toward the three-day inpatient stay requirement for SNF coverage.
- Reform the Medicare Recovery Audit Contractor (RAC) program to ensure that hospitalists and their hospitals are not unduly and unnecessarily pressured to make admission decisions based upon the expectation of RAC audits and payment denials.

### *Long-Term Solutions: Eliminate Observation Status and Replace with a New System*

- Create a low-acuity modifier to be applied to Medicare diagnosis-related group (DRG) payments that accounts for patients who require fewer or less-intensive hospital resources.
- Create a list of short-stay/low-acuity inpatient DRGs that would account for many, but not all, patients who require inpatient care for short periods of time.
- Eliminate observation status entirely and simplify the Medicare payment system with a budget-neutral formula that accounts for the changes that allows patients to get hospital care when they need it without acuity determination or differences in reimbursement.

It is clear that the current use of observation status is not a sustainable policy. Providers, hospitals and their patients are feeling unnecessary pressures from observation policy and, in many cases, patient care is being undermined. Hospitalists resoundingly agree that the policy requires significant changes focused on solving the myriad problems underlying the current system.

After a patient presents to a hospital emergency department, clinic, or transfers from another facility, providers must make a decision to admit that patient as an inpatient, discharge them, or place them under observation. This decision should ideally be based on the patient's condition and the provider's clinical judgment as to the best course of action for his or her care. However, the intricacies of observation status policy have created a situation where all patients may not be getting the care they need, and physicians may not be able to make clinical decisions themselves.

Observation status was originally intended to be utilized when a patient's condition requires additional time and monitoring prior to diagnosis. According to the Centers for Medicare & Medicaid Services (CMS), observation is defined as the following:

“ A well-defined set of specific, clinically appropriate services, which include treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital ... and in the majority of cases the decision ... can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do outpatient observation services span more than 48 hours.<sup>1</sup> ”

Under Medicare payment policy, observation status is considered an outpatient service. As such it is billed under Medicare Part B, which covers physician visits, outpatient services and home healthcare. Patients hospitalized under observation can encounter significant financial burdens because Medicare Part B may carry greater out of pocket costs than Part A. Medicare Part B services have a deductible and 80/20 cost sharing (80 percent Medicare/20 percent beneficiary) that is applied to all services provided and does not cover the cost of pharmaceutical drugs used in the hospital. This means that depending on the services provided under observation status, beneficiaries can experience highly variable financial liabilities. In contrast, inpatient services are covered under Medicare Part A and subject to a consistent one-time deductible for the benefit period. Access to post-acute services is also impacted, since any time spent under observation does not count toward the three-day prequalifying stay required for Medicare coverage of skilled nursing facility (SNF) care.<sup>2</sup>

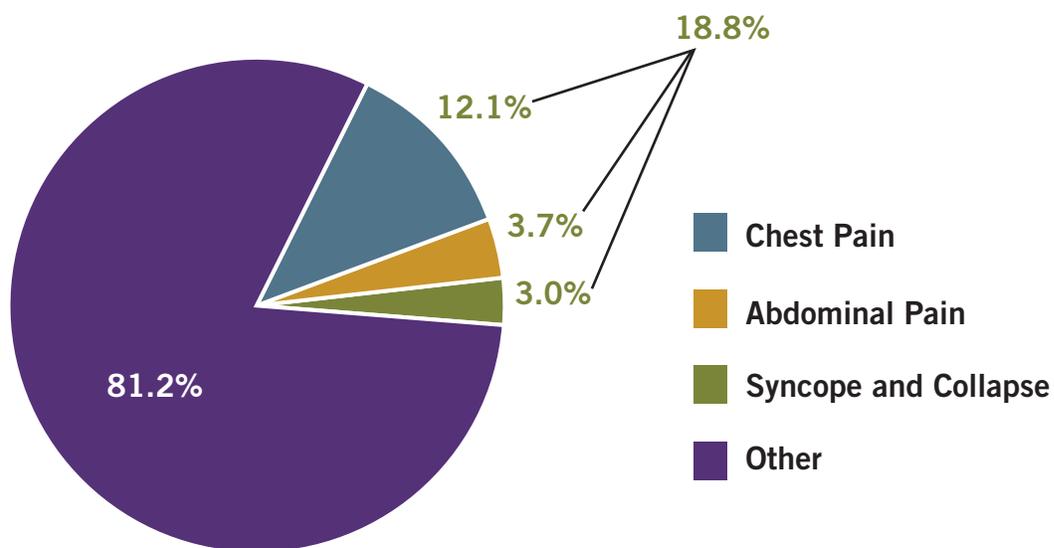
It is worth noting that a recent Office of Inspector General (OIG) report suggested that observation patients may pay less out of pocket than inpatients. However, the observation Part B dollar amounts used in the OIG report were only estimates, and the report lacked information on services delivered, making it difficult to compare out of pocket expenses because reimbursement and patient out of pocket costs are a function of both the services billed and the insurance coverage for those bills (Medicare Part A versus Medicare Part B). In fact, the only head-to-head comparison of a specific service was for coronary stent insertion, where observation patients paid \$817 *more* out of pocket than inpatients.<sup>3</sup> A more comprehensive report detailing reimbursement and patient out of pocket expense for equivalent services delivered under both observation and inpatient status would demonstrate the specific financial risk for these patients.

Patients are being encouraged to be aware and fight these status determinations, often stressing the physician-patient relationship as providers try to navigate Medicare rules, sound patient care and patient wishes.

Difficulties with observation status have been the subject of many recent media reports, garnering popular attention and galvanizing beneficiaries and their families.<sup>4</sup> Patients are being encouraged to be aware and fight these status determinations, often stressing the physician-patient relationship as providers try to navigate Medicare rules, sound patient care and patient wishes.

Today, observation status has drifted far beyond its original intent and is negatively impacting patients, healthcare providers, hospitals and the healthcare system overall.

### Presenting Symptoms of Patients with “Observation Status” at an Academic Medical Center



The current form of observation care is often indistinguishable from inpatient services; in practice, it is not a “well-defined set of specific, clinically appropriate services.” A recent study at the University of Wisconsin Hospital and Clinics identified a total of 1,141 distinct ICD-9 condition codes associated with observation status billing claims during the 18-month study period. As depicted in the chart above, the top three observation diagnosis codes were chest pain, abdominal pain, and syncope and collapse, which accounted for only 18.8 percent of total observation encounters. The large number of diagnosis codes, combined with the fact that the top three codes accounted for less than one-fifth of all observation encounters, demonstrates that observation status is not “well-defined” and suggests that observation policy is markedly different from what is occurring in real clinical practice.<sup>5</sup>

Although observation care is not meant to exceed 24 hours, and should only in rare and exceptional cases exceed 48 hours, it is not uncommon for patients to be under observation longer than these time periods. In the retrospective study conducted at the University of Wisconsin Hospital and Clinics, 16.5 percent of observation stays lasted more than 48 hours (N=756/4,578), and the mean observation length of stay (LOS) was 33.3 hours.<sup>6</sup>

This trend of increasing use and length of observation stays is well-documented. Indeed, in promulgating recent policy changes, CMS cited the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours has increased from 3 percent in 2006 to an estimated 8 percent in 2011.<sup>7</sup> More recently, the OIG reported that in 2012, 11 percent of all observation stays lasted for three nights or more.<sup>8</sup> Additionally, in a study reported in *Health Affairs*, the prevalence of observation stays rose from an average of 2.3 per 1,000 beneficiaries per month in 2007 to 2.9 in 2009.<sup>9</sup> The most recent Medicare Payment Advisory Commission

(MedPAC) report documents a 28.5 percent increase in outpatient services per Medicare beneficiary from 2006–2012 with a concomitant 12.6 percent reduction in inpatient discharges over this same period. In real numbers, this equates to an increase in observation claims from 28 to 53 per 1,000 Part B beneficiaries per year, with a decrease in inpatient stays from 334 to 289 per 1,000 Part A beneficiaries over this same period.<sup>10</sup> It is clear from these data that observation status is growing, both in duration and incidence.

The increase in the use of observation status may be attributed to multiple origins, ranging from pressures from the Hospital Readmission Reduction Program to improvements in clinical practice that have shifted services that were traditionally performed in inpatient settings to outpatient departments of the hospital. In addition, the OIG attributes some of it to a reduction in short inpatient stays, which are considered stays lasting less than two nights.<sup>11</sup> These programs and changes in healthcare are placing an inordinate amount of pressure on health systems by exacerbating the intrinsic issues with observation status policy.

Since Medicare generally pays a lower rate for observation services than inpatient services, there is an inherent conflict in making status determinations. To mediate this conflict, Medicare’s Recovery Audit Contractors (RACs) have been charged with auditing and enforcing the appropriateness of payments including inpatient versus observation status determinations. The RAC program pays independent contractors on a contingency basis for the amount they recover for Medicare. Thus, RACs are incentivized to overturn hospital inpatient claims and deny reimbursement for services rendered. Consequently, hospitals may be utilizing observation status more frequently in response to audits and fear of a lengthy and costly appeals process that may result in loss of the ability to rebill an inpatient claim as observation if the process extends beyond 12 months after patient discharge.

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## Observation Status and the “Two-Midnight Rule”

In an attempt both to curb the increasing use of observation care and address the increased incidence of long observation stays, CMS proposed and finalized a new rule that would offer a time-based criterion for when observation status should be used. In what has now become known as the “two-midnight rule,” any patient whose hospital stay is expected to cover at least two midnights is generally considered inpatient. Likewise, if a patient’s stay is expected to be less than two midnights it is generally to be classified as observation.

The two-midnight rule went into effect on October 1, 2013. Under pressure from hospitals, physicians and Congress,<sup>12</sup> just days prior to October 1, CMS issued a temporary halt on auditing and enforcement of the two-midnight rule. Instead, CMS set up a “probe and educate period,” a time in which Medicare Administrative Contractors (MACs) would select a very small sample of inpatient hospital claims, deny those claims if an inpatient stay was deemed unnecessary and allow hospitals to rebill.<sup>13</sup> The purpose of this initiative was to offer further guidance and education without penalizing hospitals. While this initiative was intended to last until December 31, 2013, CMS responded to lingering confusion by extending the education period another three months to March 31, 2014 and again through September 30, 2014.<sup>14</sup> As part of the Protecting Access to

Medicare Act of 2014, which also averted the 24 percent Sustainable Growth Rate cut in Medicare Part B reimbursement, full enforcement of the two-midnight rule was statutorily delayed through March 31, 2015. In the interim, CMS is further exploring methodologies for short inpatient stay payments with the intent of relieving some of the conflict and confusion surrounding the inpatient admission decision.<sup>15</sup>

In conjunction with the delays, the two-midnight rule also faces several pending lawsuits. In April 2014, the American Hospital Association (AHA) and other stakeholders filed two lawsuits against the Department of Health and Human Services.<sup>16</sup> The lawsuits focus on the arbitrary standards of the two-midnight rule and the resulting denial of proper reimbursement for care provided. The plaintiffs also claim the rule's strict, time-based criterion undermines medical judgment.

While the two-midnight rule is intended to offer some level of clarity on inpatient admissions, it has certainly failed to respond to many of the issues inherent to observation status. It does not alleviate the pressures that these status determinations place on the physician-patient relationship. It does not decrease financial barriers, such as access to necessary post-acute care, as patients under observation still do not qualify for skilled nursing care after discharge. It has created a situation where the time of day a patient becomes ill, not clinical needs, may determine whether the patient is eligible for Medicare Part A coverage. It has also shifted the burden of observation to those staying less than two midnights, many of whom may have been inpatient under prior policy.

While the two-midnight rule is intended to offer some level of clarity on inpatient admissions, it has certainly failed to respond to many of the issues inherent to observation status.

### What is the Role of Hospitalists in Observation Status Policy?

Hospitalists are central players in the inpatient admission decision. They are commonly the admitting physicians making these decisions and are primary points of contact helping patients navigate the consequences. The two-midnight rule and the use of observation status in general is an area of significant concern among SHM's more than 13,000 hospitalist members.

Since hospitalist feedback on observation policy had never been formally collected, SHM developed a 28-question survey including two free-response questions that captured its members' perspectives and experiences. The "Experiences and Perspectives of Observation Status" survey received responses from 378 hospitalists and generated 447 written free responses, further illustrating how central the issue of observation status is to hospitalist practice. Hospitalist depth of experience with status determinations will be critical in developing workable solutions for observation policy that account for both clinical realities and the delivery of high-quality patient-centered care.

With their unique vantage point of caring for patients in the hospital, hospitalists see firsthand the impacts of observation status policy on patient care. Nearly all (93 percent) of respondents rated observation policy as a critical policy issue for them and their patients.

For hospitalists, there are three major areas of concern with observation status policy:

- The two-midnight rule and its failure to simplify admission decisions
- Impacts on patients, including coverage and financial barriers
- Impacts on clinical care and practice

## Current State of Observation Policy: The Two-Midnight Rule

Because of its relatively recent promulgation, the two-midnight rule is at the forefront of any discussion on observation status. CMS' original intent with the policy was to decrease the use of observation, create a simpler system for providers and hospitals to make admission decisions, and maintain physician autonomy in these decisions. Despite these aims, the two-midnight rule has been the subject of much controversy and scrutiny as providers attempt to navigate these new requirements for inpatient admissions.

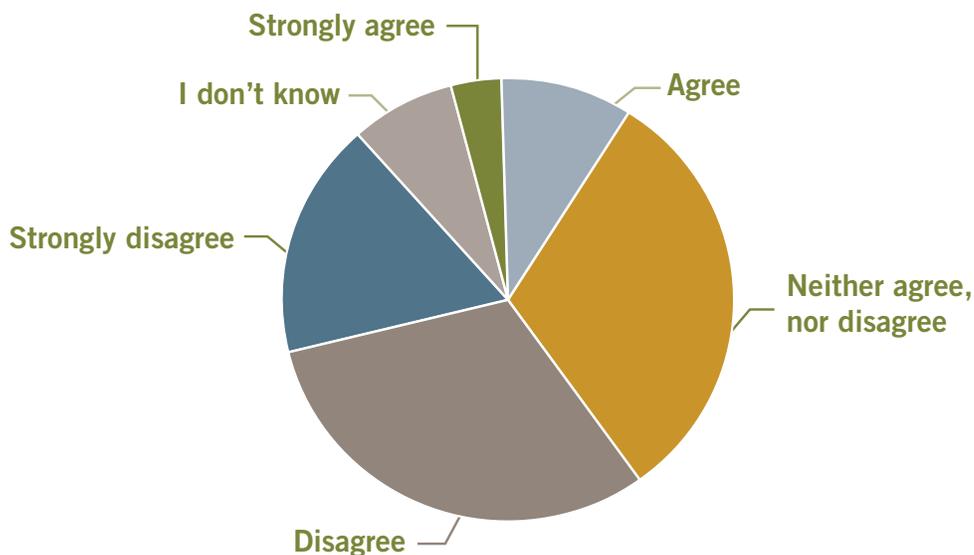
Compared to prior observation policy, hospitalists report equivalent levels of understanding of the two-midnight rule and the longstanding prior policy, 68.5 percent and 65.6 percent, respectively. At the same time, less than half of all respondents (46 percent) reported receiving formalized training on the new rule. This suggests that, even with aggressive attempts to provide educational opportunities to the physician community, CMS has not been able to connect meaningfully with more than half of hospitalists on the two-midnight rule.\* It also calls into question whether CMS' original intent to achieve a simpler decision-making system is realized by the two-midnight rule. A simpler system should achieve significant gains in understanding — a goal that remains unrealized in light of the two-midnight rule in its current form.

While a general awareness of the two-midnight rule may be evident, hospitalists are not confident in its application. In fact, less than half of respondents (40.4 percent) expressed confidence in determining their patients' status on their own. Only a slightly higher number of hospitalists (46.3 percent) were more confident in making these decisions with the assistance and input from other players or systems in their hospitals, including case managers, electronic health records/clinical decision support devices, coding and compliance administrators, and external review organizations. As one survey respondent notes:

**“I am part of the utilization committee and serve as a physician advisor to help determine inpatient vs. observation level of care. I have received special training and still don't feel I have a good grasp on how to assign level of care for all patients.”**

\* CMS made available a number of educational materials for providers following the publication of CMS-1599-F, which established the two-midnight rule. This guidance was in response to the outpouring of criticism and concern from the provider and hospital communities as to their responsibilities under the new policy. Included in these materials were Open Door Forums/National Provider Calls, guidance documents, clarifications and Q&As.

### Does the Two-Midnight Rule Improve Hospitalist Workflow?



Regarding hospitalist workflow, more than half (55 percent) of respondents disagree or strongly disagree that the two-midnight rule improves hospitalist workflow compared to the previous observation policy. Another 29 percent were unsure about the impact of the policy on their work. This is likely indicative of the fact that the two-midnight rule is not a policy improvement. However, this finding may also reflect the timing of the survey, as it was possible that hospital implementation of the two-midnight rule was still occurring coincident with the administration of the survey, potentially affecting the responses.

These results echo sentiments across the healthcare system that the two-midnight rule has confused and complicated the admission decision.

The very physicians who are central to these status decisions are struggling with the real-life application of the two-midnight policy. Perhaps unsurprisingly, the two-midnight rule is not viewed positively by hospitalists who are attempting to put it into practice. Almost half (47 percent) of respondents thought the rule has negatively impacted patient care, while only 17.4 percent of respondents see the rule as an improvement.

These results echo sentiments across the healthcare system that the two-midnight rule has confused and complicated the admission decision. It has not improved or simplified the process.

### Impacts of Observation Status on Patients

While observation policy generally sets a time-based requirement for inpatient admission, it fails to ensure and may even prevent patients from receiving the complete care they need. Observation status policy creates multiple impediments for patients, including lack of coverage for SNF care, lack of coverage for medications, uncertain cost sharing and other financial liabilities.

Access to post-acute SNF care is a major point of tension for hospitalists and their patients. One of the most common written free responses centered on patient barriers to SNF care, and recommendations that time spent under observation should count toward the three-day prequalifying requirement for post-acute care. One representative hospitalist explains her concerns:

**“ Take away the requirement for a three-day inpatient stay for Medicare patients to qualify for SNF coverage just as what applies for Medicare Advantage patients. This will help avoid unnecessary hospital admissions and allow Medicare to reduce their costs but still provide safe care for eligible patients. Discharge to post-acute care should not be linked to observation status. This is a major barrier regardless of what the rule is. Some patients of low acuity are still unsafe to return home. This needs to be fixed! ”**

Many hospitalists broadly discussed the financial burdens of observation status in their written survey comments and call out the false nature of what it means to be under observation:

**“ It is not fair to require a patient to stay in the hospital overnight and then have them foot the bill — they can choose to go or not go to an outpatient appointment but if they are sick enough to be ‘observed’ [in the hospital] then they should be inpatient, they do not have the medical training to make an informed cost decision. ”**

Hospitalists also indicated that patients are overwhelmingly uninformed of their status. A total of 43 percent of respondents did not know if their patients were notified of their status, with almost 10 percent reporting that their patients are simply not notified at all. New York, Maryland and recently Connecticut are the only states that explicitly require hospitals to inform patients of their status, although some hospitals may create policies to notify patients on their own.

Many hospitalists believe that at the very least patients should be notified of their status. Although simply informing patients of their status does not ameliorate the many negative impacts of observation status, it would at a minimum raise awareness:

**“ [We should] more clearly communicate the purpose of observation status to the patients. Because there is [sic] greater out of pocket costs, patients are angered by this and object to observation status which creates discontent among providers. Patients perceive the hospitals are finding ways to recover costs rather than following a CMS regulation. ”**

Even with notification of their status, patients are still confused about how being in a hospital bed can result in two very different coverage realities. As one hospitalist stated:

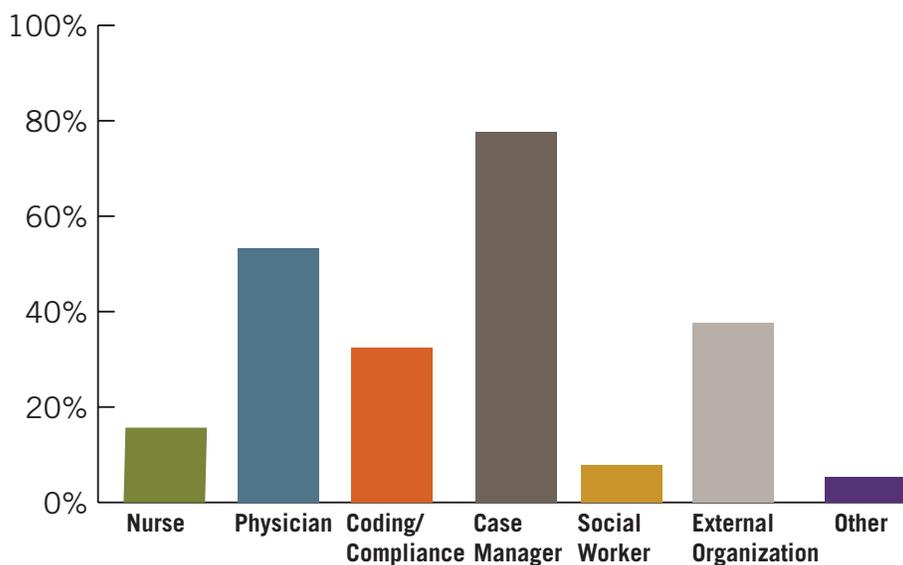
**“ The patient needs to be educated on what observation means. The equality of ‘being in a hospital bed’ and ‘inpatient admission’ either needs to be dispelled or solidified. Right now it is not clear. ”**

The impact on patients — and hospitalists’ experiences of that impact — cannot be understated. Observation status is a payment policy that is not only detrimental to the provision of patient care but also serves as a barrier for patients needing that care.

### Clinical and Practice Implications for Hospitalists

The complexity of patient status determinations has limited the ability of providers to make independent clinical decisions. The overwhelming majority of respondents (78 percent) reported case managers being involved in status determinations.

In Your Hospital, Which of the Following Provides Input in Reviewing Inpatient Versus Observation Status Determinations?



In addition, many hospitalists reported the use of externally contracted organizations to help make these decisions. The perception of limited autonomy was reiterated numerous times:

“Develop a system that is easy for hospitalists to understand and implement. Our hospital has hired an outside consultant to help, but this is an added cost.”

Hospitalists want to make these decisions, but are constrained by complexities and financial pressures created by the policy.

Hospitalists report they are asked to change the status of their patients for 16 percent of the cases they see on an average day of clinical service. This means that the status of one of every six hospital patients is reviewed by multiple parties, analyzed against current Medicare policy and ultimately changed into a different status. This results in significant outlays in time and resources in order to ensure compliance with observation rules. Overall, observation status significantly burdens hospitalist workflow, takes time away from patient care and ultimately adds cost to the Medicare system as a result of lost productivity and efficiency.

One of every six hospital patients' status is changed as a result of review by multiple parties.

Most importantly, the physician-patient relationship suffers as a result of observation policy both before and after implementation of the two-midnight rule. The policy pits patients against providers in trying to make these status determinations that do not reflect clinical reality. When determinations are not in favor of the patient, hospitalists are viewed as agents of the system rather than champions of good clinical care. It is telling that hospitalists are reporting their frustration and exasperation with being caught between advocating for their patients and running afoul of Medicare regulations:

**“ I have now spent many hours of my day trying to discuss with patients and their families a rule I don't understand and I have had a number of people refuse to be admitted for care they need due to concerns over status and what their bill will be. These are legitimate concerns and I want to be able to advocate for my patients but cannot in the current state. ”**

Observation status policy directly and unnecessarily stresses the physician-patient relationship. Indeed, it is not uncommon for patient frustrations with the policy and its shortcomings to be directed at the hospitalist, case managers and the hospital. In effect, observation status is undermining the trust that patients have in their doctors and hospitals to provide them with the best care possible.

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## Short-Term Improvements

In the short term, it appears that observation status will continue to be present in some form. Whether that is the two-midnight rule, a reversion to the prior observation policy or some alternative system, there are several areas that could improve the experience of the policy for providers and patients alike. Based on responses in the survey, SHM has identified the following priority areas for short-term improvement:

- **Provider Education:** Further education is needed on observation policy to raise proficiency and confidence in applying the rules. While many hospitalists seem to have a good understanding of observation policy, they are not highly confident in the real-time application of either the two-midnight rule or the prior policy in practice. Regulations and associated guidance need to be clearly articulated, easy to follow and rooted in clinical realities.
- **Patient Education:** Right now, observation status is a central point of contention for hospitalized patients, and hospitalists are bearing the brunt of patients' and families' frustrations with the policies. Medicare needs to provide clear and concise education to patients as to the intent and purpose of observation status, and must outline the myriad impacts of observation status on patient care. Patients need to know exactly how these policies affect access to care and what their out of pocket costs will be for observation care services, hospital medications and subsequent SNF care.
- **Changes to SNF Care Coverage:** This is a major point of concern for patients and hospitalists alike, and is easily improved in the short term. At a minimum, time spent under observation status should count toward the three-day inpatient stay requirement for SNF coverage.
  - SHM strongly supports the passage of H.R. 1179/S. 569, the Improving Access to Medicare Coverage Act, which would count observation time toward the three-day requirement.
- **Reforms to the RAC Program:** As the RAC program and the threat of lost payment is a key driver of contention around the admission decision, improvements to the RAC program would help ameliorate some of this pressure. RAC auditors are paid exclusively on contingency as a percent of their recoveries for the Medicare program. This has incentivized aggressive auditing, without transparency, accountability or repercussions for unnecessary audits. Both audits and the threat of audits create workflow pressures in day-to-day practice, ranging from changes in status determinations to extensive documentation requirements to defend physician judgment. Decisions should be made based on the needs of the patient as determined by their physician, not on the likelihood of RAC audits and payment denials.
  - SHM supports the recent Inspector General recommendation to CMS to “develop additional performance evaluation metrics to improve RAC performance and ensure that RACs are evaluated on all contract requirements.”<sup>17</sup> This is a critical first step toward reforming the RAC program.

Numerous hospitalists and other stakeholders have also recommended reverting to the old observation policy, which relied on clinical criteria for admission decision making.

## Long-Term Solutions: Eliminate Observation Status and Replace with a New System

Hospitalists have spoken resoundingly about the inherent flaws within observation status policy overall. It is clear observation status has strayed far from its original intent. In its current form, observation status makes little, if any, clinical sense and is only having a detrimental effect on patients and confounding providers.

Based on responses to the survey and feedback from a wide range of members, SHM has identified potential options for long-term, more comprehensive solutions to observation status. However, with the experience of the introduction of the two-midnight rule, SHM recommends the use of Medicare pilot programs to explore the feasibility of any replacement system. Such pilot programs could be used to develop clear and concise guidance prior to national rollout, identify problems and unintended consequences for amelioration and even determine if a solution should be eliminated as unworkable before time and effort are expended on a national scale. Multiple viable options could even be piloted simultaneously, which would allow for faster identification of the most workable alternatives. A few potential options are as follows, although there are certainly others that hold merit. All would require the elimination of observation status in its current form.

### Option A: Create a Low-Acuity Modifier for Most DRGs

Based on clinically appropriate rules, providers would indicate when a particular patient requires lower-acuity services during his or her stay in the hospital and assign a lower-acuity modifier to the patient's current DRG (for example, simple pneumonia and pleurisy DRG 089 vs. simple pneumonia and pleurisy DRG 089<sup>low-acuity</sup> depending on the patient's clinical acuity). This would be noted in the billing claims and a payment adjustment would be applied to that DRG claim. Such a program would be comprehensive of most DRGs and would account for most conditions in the hospital. (Certain DRGs, such as acute STEMI, would not be eligible for the adjustment based on the intensity of services required.) Providers could even apply this modifier retrospectively once a patient's condition and clinical needs are fully known.

SHM believes that this option would be comparatively easy to design and implement. It recognizes the general lack in clinical distinction between patient populations in the inpatient and observation settings. Expanding on this point, many of the patients who are seen under observation status would and could theoretically be covered under Part A/inpatient services if not for the policies around observation status. It would also virtually eliminate the myriad patient-level issues associated with observation status and enable observation status to return to its original intent. At the same time, under this rule, the use of audits would still be prevalent to ensure proper application of the modifier, necessitating RAC reform as described above.

## Option B: Create a List of Short-Stay/Low-Acuity Inpatient DRGs

Many stakeholders have expressed interest in creating a methodology for a short-stay/lower-acuity inpatient DRG system. In fact, CMS requested information and advice on creating such a list in the 2015 Inpatient Prospective Payment System proposed rule (CMS-1697-P). This would enable providers to bill Part A services for a select group of short-stay/lower-acuity DRGs, thus granting those patients access to the Part A cost-sharing structure and access to SNF coverage. However, the ability to identify even a fraction of the DRGs that might be applicable may be unduly burdensome. As previously discussed, the top three diagnoses in observation status at the University of Wisconsin, Madison accounted for less than one-fifth of total observation encounters.<sup>18</sup> This reality adds greatly to the complexity and difficulty of establishing this option. Also, this option would still leave observation status intact for many cases and keep a system in place where subjectivity and RAC auditing would continue in a similar fashion to what currently exists.

## Option C: Eliminate Observation Status Entirely and Simplify the Payment System

Many of the survey respondents stated that observation status should be eliminated entirely. SHM encourages exploring the development of a viable replacement that meets the needs of patients, providers and the Medicare program, while simplifying the Medicare payment system. Under this option, all patients admitted to the hospital would be considered inpatients and therefore share the same financial liabilities. Hospitals would save on costs related to RAC oversight and the use of costly external services (external review organizations, Milliman, Interqual, etc.) to make status designations. As one hospitalist offered:

**“Stop distinction on observation versus inpatient — it’s nearly impossible for physicians and patients to understand and get right. It’s an arbitrary distinction for medical patients. It would be better to say that all hospitalized patients would be under Medicare Part A than to have the patients under multiple payment schemes.”**

SHM recognizes the difficulty in implementing this option and that it would need to be enacted in a budget-neutral manner. This would likely be a challenging reform to enact and implement. Concerns could be minimized through the careful development of a formula to account for these changes. Patients could be admitted to the hospital as inpatients without acuity determination, or difference in reimbursement. This could be coupled with the initiation of a data-monitoring program with the end results being shared utilization goals between the Medicare program and providers. This might also be tested in Accountable Care Organizations (ACOs) in which shared-savings programs may provide the right venue to pilot such a model. SHM acknowledges that this option would require major restructuring, but would provide more clarity and consistency for providers and patients alike.

It is clear that the current use of observation status is not a sustainable policy. Providers, hospitals and their patients are feeling unnecessary pressures from observation policy and, in many cases, patient care is being undermined. Hospitalists resoundingly agree that the policy requires significant changes that need to be focused on solving the innumerable problems underlying the current system.

Any policy change should be rooted in common sense, reflective of clinical reality and designed to ensure that patients and providers are incentivized to work together to improve health. Patients should be able to get the care that they need — when they need it — including access to SNF care. Medicare policies should not be unnecessary impediments to physician judgment and workflow and should be geared toward reducing administrative burden and complexity. It is also imperative that any change in policy recognizes that patient admission decisions have downstream impacts on beneficiaries and their access to care. Additionally, SHM cautions that any reform to observation status and inpatient admissions will not be successful unless there is concurrent reform of the federal auditing programs that enforce these rules.

Admission status should not be replete with the tensions and challenges described by hospitalists and many others. A comprehensive review of the policy requirements and clinical realities is necessary to create a responsive set of policies that ensure patients are getting the care they need. A payment policy that provokes confusion amongst providers and potentially harms the beneficiary should be scrutinized more critically.

Any changes in policy should reflect the reality that observation care is inpatient care, and should be billed as such to Medicare Part A. As inpatients, those once designated as requiring observation would have the ability to access post-acute care when they need it, and would not be faced with difficult decisions about whether or not they must forgo or shorten requisite services due to cost or arbitrary rules. For hospitals and hospitalists, admission policies should be easy to understand, and also reduce impediments to workflow, defer to physician judgment and decrease administrative burden. Much work is needed to achieve these goals and any potential solutions need to be carefully evaluated prior to national implementation.



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